Universal Health Coverage for Inclusive and Sustainable Development

Country Summary Report for France

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Health, Nutrition and Population Global Practice
The World Bank Group
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ALD</td>
<td>Chronic conditions (affections de longue durée)</td>
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<tr>
<td>CAPI</td>
<td>Pay-for-performance pilot mechanism for office-based General Practitioners</td>
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<tr>
<td>CNAM</td>
<td>National Sickness Fund (Caisse nationale d’assurance maladie)</td>
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<tr>
<td>CSG</td>
<td>General Social Contribution</td>
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<tr>
<td>CMU</td>
<td>Universal Medical Coverage</td>
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<tr>
<td>DRG</td>
<td>Diagnostic-related groups</td>
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<tr>
<td>IRDES</td>
<td>Institute for Research and Information on Health Economics</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>ONDAC</td>
<td>National Objective for Health Care Spending</td>
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<tr>
<td>OOP</td>
<td>Out of pocket health spending</td>
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<tr>
<td>PPP</td>
<td>Purchasing power parity</td>
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<tr>
<td>SHI</td>
<td>Social Health Insurance</td>
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<tr>
<td>T2A</td>
<td>Activity-based payment system</td>
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<tr>
<td>THE</td>
<td>Total Health Expenditure</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>UNCAM</td>
<td>National Union of Sickness Funds (Union nationale de caisses d’assurance maladie)</td>
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<tr>
<td>VHI</td>
<td>Voluntary Health Insurance</td>
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Preface

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself. This led to the formation of a joint Japan–World Bank research team under The Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the generous support of the Government of Japan.

This Country Summary Report on France is one of the 11 country studies on UHC that was commissioned under the Japan–World Bank Partnership Program. The other participating countries are Bangladesh, Brazil, Ethiopia, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam. A synthesis of these country reports is in the publication “Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies,” available at:


These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.
Acknowledgments

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The Program was led by a team comprising Akiko Maeda, Lead Health Specialist and Task Team Leader for the World Bank, and co-Team Leaders, Professor Naoki Ikegami, Department of Health Policy and Management, Keio University School of Medicine and Professor Michael Reich, Taro Takemi Professor of International Health Policy, Harvard School of Public Health.

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The report was edited by Jonathan Aspin.

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Country Summary Report for France

Overview

Situated in Western Europe, France is a high-income country with a gross national income (GNI) above $40,000 per capita. While the overall picture of health status is good, France contains apparent contradictions. Life expectancy is overall better than in many European countries, but premature male deaths remain high due to accidents, smoking, and alcoholism. Social and geographic inequalities in health are substantial, to the disadvantage of the northern parts of metropolitan France and overseas departments and territories. The French system largely relies on Bismarckian-based Statutory Health Insurance (SHI), established after the Second World War. Universal coverage was fully achieved in 2000 when a new law (Universal Medical Coverage Act, or CMU by its French acronym) expanded coverage to noncontributory low-income groups. Financial sustainability of the model has been a recurrent concern over the last three decades. Recent shifts in the funding model and the introduction of spending targets and efficiency measures have injected some flexibility to the system.

Table 1. Data overview

<table>
<thead>
<tr>
<th>Population</th>
<th>65.4 million</th>
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<tbody>
<tr>
<td>GDP</td>
<td>$2,214 billion</td>
</tr>
<tr>
<td>GNI per capita in purchasing power parity (PPP)</td>
<td>$41,018</td>
</tr>
<tr>
<td>Total health expenditure (THE) as % of GDP</td>
<td>11.6</td>
</tr>
<tr>
<td>THE per capita (in US dollars PPP)</td>
<td>3,974</td>
</tr>
<tr>
<td>Out of pocket spending as % of THE</td>
<td>7.5%</td>
</tr>
<tr>
<td>Public expenditure ratio of THE</td>
<td>77%</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>81.5</td>
</tr>
<tr>
<td>Hospital beds per 1,000 population</td>
<td>6.4</td>
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PART I. UNIVERSAL COVERAGE—STATUS AND SEQUENCING

A. Overview of current status

1. Legal and statutory basis

The French health insurance system was shaped over a century but a major boost to setting up a nationwide compulsory program took place just after World War II. In 1945, a general insurance program was adopted under the Social Security Act with the goal of providing uniform rights for all in five areas: illness, maternity, disability, old age, and death. In practice, expansion of health insurance coverage to various population groups followed an incremental process over the following two decades. General statutory insurance was extended to farmers in 1961 and to the self-employed in 1966, but access to health insurance remained problematic for very low income groups and people with variable (nonsalaried) incomes until 2000 when the CMU came into effect. The new law opened the right to health insurance for all legal residents who were not previously covered.

2. Population coverage

The SHI system consists of three main programs. A General Program (called the Régime Général) covers workers in business, trade, and industry, and their dependents (84 percent of the population) and civil servants. CMU beneficiaries are also managed by the General Program. The Agricultural Program relates to farmers and agricultural employees and their dependents (7 percent), while the program for the self-employed recently merged various programs for independent professionals (5 percent).

In addition, 16 small programs cover specific professional categories, including miners, the clergy, and employees of the National Railway Company and the Bank of France (the central bank) (1 percent).

Illegal residents are also covered by a mechanism (Aide Medical d'Etat) which provides access to basic health services through direct government funding.

Enrollment in insurance programs is compulsory and automatic for workers. Consumers do not have the choice of program or insurer, and cannot opt out. Apart from the CMU, enrollment follows employment category, which means that an agricultural worker automatically comes under the Agricultural Program and is not allowed to switch to the General Program. There are thus no competing health insurance markets in France.

Benefits and copayments are fixed across population groups, while levels of wage-based contributions vary across programs.

3. Service coverage

Population groups are covered through different programs, but the same comprehensive health benefit package today applies to all programs across the country, including CMU beneficiary groups. Each SHI member has legally equal access to equivalent services, whatever their program.

SHI provides access to this comprehensive package, which offers a wide range of medical services and goods compared with other countries in the Organisation for Economic Co-operation and Development (OECD). The package is defined through explicit positive
lists/catalogues of covered services, drugs, and devices/equipment. Catalogues also list excluded medical procedures (such as thermal spa treatment, chiropractic, and cosmetic surgery). Drug catalogues are different for hospitals and ambulatory care. Volumes of care are generally not specified for common products and care; volumes can, however, be capped for expensive drugs, devices, or innovations (e.g. a maximum of four intra-uterine fertilizations).

Prevention services have been somehow neglected in the benefit package as the system has focused on treating diseases from the outset. Recent preventive programs introduced for immunization or cancer screening are now covered by insurance programs, though general public health programs are still funded directly from the budget.

4. **Financial protection**

The insured are encouraged to enroll in complementary insurance provided by *mutuelles*, provident firms and private firms. A total of 94 percent of the population is now enrolled in Voluntary Health Insurance (VHI) programs, which generally cover patients’ full copayment, though disparities persist across contract provisions.

Reimbursement is a distinctive feature of the French cost-sharing system. The insured are expected to pay first for ambulatory care and to claim reimbursement from insurance funds, based on predefined rates. Exceptions have, however, become the rule as more and more patient groups are eligible for a third-party payment system (*tiers payant*), which prevents them from making the initial advance. Some population groups are completely exempt from copayments, mainly patients with long-term chronic diseases (such as the program for chronic conditions “ALD - affections de longue durée”), pregnant women/newborns, and CMU beneficiaries.

SHI accounts for 75.5 percent of Basic Health Expenditures\(^1\) in 2011, complementary voluntary insurance 13.7 percent and direct private spending 9.6 percent. SHI spending fell from 76.7 percent of Basic Health Expenditures in 2000 to 75.5 percent in 2011, when the share covered by VHI increased from 12.4 percent to 13.7 percent.\(^2\)

When SHI and VHI are combined, France offers some of the highest financial coverage of health expenses among OECD countries. Net out-of-pocket spending (after SHI and VHI reimbursement) stayed quite stable in the last decade (around 9.6–9.7 percent). However, out-of-pocket spending more than doubled during 1980–2008 in PPP\(^3\) under the combined effect of an increase in THE and a continuous reduction of the financial share of SHI owing to cost-containment measures.

5. **Governance and regulation rules**

Regulation of the health insurance system is divided mainly between the state (Parliament and the government with several ministries) and the SHI funds. The National Sickness Fund (Caisse nationale d’assurance maladie, or CNAM), operating under the General Program, is the predominant (almost only) SHI payer.

In 2004, a series of reforms began to shift financial stewardship to health insurance funds by giving them more control over benefit packages, tariffs, and levels of copayments. The reforms also modified governance of the health insurance funds. A federation of sickness funds has

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1. Includes medical goods and services (*biens et service medicaux courants*).
2. Source: Direction de la recherche, des études, de l’évaluation et des statistiques (DREES).
3. Source: Eco-santé: from €217 to €547 per capita a year.
been created to bring together, nationally, the three major programs. This federation (Union nationale des caisses d'assurance maladie, or UNCAM) is now the sole representative for negotiating with the government and health care providers.

B. Current status of health financing and human resources for health (HRH) policies

1. Financing

Until the end of the 1990s, SHI financing depended almost exclusively on payroll contributions from employers (63 percent) and employees (32 percent). Since 1998, most of the employee payroll contribution has been substituted by an earmarked tax. A General Social Contribution (CSG) levied at 5.25 percent on earned income and income from capital and 3.95 percent on benefits is now one of the main sources of SHI funding (37 percent). Taxes on tobacco, alcohol, and the pharmaceutical industry add to the revenue base.

2. Delivery mechanisms and payment system

The delivery system is shared among the private and public sectors. Primary care is almost exclusively delivered through self-employed physicians paid on a fee-for-service basis. The main tariff (“Sector 1”) is negotiated nationally between general practitioners (GPs), the Ministry of Health, and sickness funds. Practitioners can opt for a “Sector 2 system”, which allows them to top-up their fees but they lose some financial advantages.

Hospital care is split among public sector (two-thirds of hospital beds), private for-profit and not-for-profit facilities. The hospital payment system has evolved over the last two decades from a needs-based approach (global fixed budget) to a more performance-oriented and public–private alignment model through the introduction of an activity-based payment system (T2A) in all hospitals. (There has also been a move to greater autonomy—See Box 1.)

Box 1. A shift to greater autonomy for hospitals in France

French policymakers sought to help public hospitals make the transition from a state-run approach to a new, more autonomous and performance-oriented approach. (The French reform process, however, did not go as far as Japan in granting hospitals autonomous authority.) Hospital oversight was transferred from the central to decentralized level—Regional Health Agencies—but public hospitals remain in the public domain.

Hospital reforms in France have consisted of a change of payment systems—from a global budget to a diagnosis-related group (DRG) system—and a new model for corporate governance. The new payment system resulted in a systemwide boost of activity volume as well as gains in productivity and efficiency. The introduction of DRG has also helped induce positive changes related to governance and care organization. Following the introduction of DRG, resource-pooling across medical units (e.g. nursing staff) and cross-subsidization (between high- and lower-cost activities) led to service rationalization in hospitals.

4 Source: Commission of Social Security Accounts (1990 figures).
5 The current rate for a GP consultation is €23 ($29).
Governance reforms translated into a new deal between administrative and medical management. Practical managerial measures were taken to better align teams with corporate goals and have led to the merger of medical units in larger departments, which has improved coherence and efficiency; the setting up of joint managing boards; contracting with medical chiefs; and the introduction of performance-based bonuses for heads of medical departments.

To be eligible for coverage, medical services and goods should be provided or prescribed by registered health care professionals. Beneficiaries can opt for the provider of their choice.

A “soft” gate-keeping system was set up in 2005, however, using a “preferred practitioner” (médecin traitant) enrollment system, entitled to coordinate care pathways and referral to specialists. Since then, patients receive financial disincentives for not opting for their declared “preferred doctor” as a first entry point in the health care system.

Although included in the initial plans, the fee schedule at the moment varies among public facilities (where it is higher) and private facilities.

3. Fiscal sustainability

France spends the third highest among OECD countries on health as a share of its GDP, at 11.6 percent in 2011, behind the United States and the Netherlands. Recurrent deficits of the SHI funds have been critical concerns for the last three decades (it was €14.5 billion in 2010). Annual growth in health spending has, though, slowed in recent years (to below 3 percent since 2010) following the introduction of macro-budgetary targets and efficiency programs at micro level.

The country has managed to diversify sources of revenue for health, and the revenue basket now consists of wages, the CSG, and other earmarked taxes, injecting more flexibility into the funding model. The government is considering options to expand the SHI’s revenue base, as well as for adjusting the activity-based payment system for hospitals (“bundled payments” is one option).

4. Cost containment and efficiency

Since the end of the 1990s, every year Parliament has adopted a National Objective for Healthcare Spending (ONDAM). There are separate expenditure targets for the hospital sector (distinguishing public hospitals and private clinics), for the ambulatory sector (doctors’ fees, prescriptions, sickness benefits, etc.), and social/long-term care (for the elderly or disabled). These targets are not compulsory. Therefore, with the exception of the first year, actual expenditure always exceeded the target until 2010. However, the introduction of targets has led France to set up a comprehensive system for monitoring health expenditure, including an “Alert” mechanism for overspending.

In the second half of the 2000s, policy measures also focused on enhancing provider performance and efficiency. On the hospital side, a major shift occurred through the introduction of T2A in both public and private structures to pay for acute care services with the objectives of improving efficiency and creating a level playing-field for payments to public and private hospitals.
The 2009 introduction of a pay-for-performance pilot mechanism for office-based GPs (CAPI) also aimed at introducing financial incentives for quality of care and cost-efficiency gains in managing chronic diseases. Although the initiative does not reform the overall fee-for-service payment system but rather adds to it, it filters in some elements of a performance-based approach with the potential to improve care rationalizing, accountability and, eventually, health outcomes (Or 2009).

5. **Equity in financing health care**

France’s health funding system is acknowledged as relatively equitable (Wagstaff and Doorslaer 1999). Changes to funding policies with new taxes may, however, question this view. More reliance on VHI also raises concerns for “solidarity” and redistribution in the French health insurance system, as in practical terms it points to more health expenses being covered out of compulsory programs, general contributions, and consequently the sick. Some argue that this shift is likely to increase inequalities in access to care across income and health groups, and to put additional pressure on the worse off, who have less or no access to VHI: 12 percent of the poorest do not have VHI against 3 percent among the better off. (As complementary insurance remains voluntary, its purchase is traditionally associated with higher-income groups.) Most VHI providers adjust contributions for age, health status, and risk. The financial coverage provided by VHI also tends to vary across incomes: 53 percent of the richest benefit from broad protection, but only 13 percent of the worse off (Bocognano et al. 2000).

6. **HRH policies**

With more than 3.4 physicians and 7.8 nurses per 1,000 population, France has relatively high medical care resources, although geographic distribution remains a concern. Lack of specialists for sectors like gynecology, psychiatry, or anesthesiology is another area of relative shortage.

The major regulatory mechanism for controlling physician supply is the yearly quotas for limiting the number of medical students. The number of doctors and other health professionals (such as nurses and physiotherapists) is regulated by the *numerus clausus*, a method used by the central government to control access to the second year of study in medical schools (the first year being accessible to all high-school graduates). In the ambulatory sector, generalists and specialists are free to choose where they work. This mainly explains the unequal distribution of doctors across regions, with a ratio of highest to lowest density of GPs by region of 1.55. The southeast, known for a better quality of life, has 367 practicing GPs per 100,000 population while northeast regions have fewer than 250 per 100,000 population (CNAMTS 2011).

In recent years, the government has introduced HRH-related measures to reduce geographic variations in the distribution of health professionals. It has:

- Increased quotas for entrance to medical schools
- Enhanced multidisciplinary cooperation between doctors and paramedics at local level through skill mix and task shifting (i.e. for dialysis to nurses and eye-glass prescriptions to optometrists) (Bourgueil 2010)
- Raised tax incentives for group practices in medically deprived areas
- Offered “Public Service Involvement Contracts” [“Contrats de service public”] to medical students with financial provision to set up practice in underserved areas.\(^6\)

\(^6\) Under the 2009 Hospital Law (HPST).
Today, group practices are in the majority: the share of private GPs declaring working in a group practice has risen from 43 percent in 1998 to 54 percent in 2009. This increase is particularly apparent among GPs aged below 40 with eight out of 10 working in a group practice. The group practice structure appears to alter GPs’ weekly work patterns without altering their weekly work volume as much: group practice GPs more often declare working fewer than five days a week but carry out more medical acts per day than GPs working alone. Group practice is equally associated with more time for training, supervising students, and greater use of computerized patient files (Baudier et al. 2010).

The effects of other HRH policies have not yet been evaluated.

C. Sequencing of reforms

From the Social Security Act’s ambitious goal in the 1940s to effective insurance coverage for all in the 2000s, it took France more than 50 years to establish a universal coverage-oriented health system. Routes to this mainly favored an employment-based coverage approach and a “gold-standard” benefit package delivered by a public–private system. Although “socio-professional” programs and insurance funds developed separately and have remained separate for historical reasons, state policies have persistently aimed for coherence and alignment across programs.

Figure 1: Milestones in the French health insurance system

The current system comes from the tradition of mutuelle-based organizations in place since the French Revolution (1789). At that time, provident societies (Sociétés de secours mutuel) provided their contributing members with financial support in the event of death or disease.

The 19th century was marked by the introduction of targeted programs run by the state to cover, among others, health risks. However, population coverage and benefits remained low, as the programs were based on voluntary contribution.

After World War I, the first compulsory program was set up for industry workers in a region bordering Germany—Alsace Lorraine. It served as a catalyst to the development of a broader insurance system in the 1930s for the whole country (the Social Insurance Act). The system was based on contributions from employees and employers in industry and business and provided coverage for illness, motherhood, disability, old age, and death. This period was
indeed marked by a deeper state involvement in social protection issues in France and beyond (the welfare state).

A major push to setting up a nationwide compulsory health insurance system took place in France just after World War II, as seen. Nevertheless, the objective of one uniform program has never been achieved, partly because differences arose from competing interests. Some occupational/professional groups (civil servants, miners, railway workers, etc.) already benefiting from insurance on more favorable terms kept their own programs—and still do. Expansion of coverage to various population groups followed an incremental process over the next two decades, and coverage for the whole population was eventually achieved in 2000 with the introduction of the CMU program.
PART II. LESSONS TO BE SHARED

France has an employment-based social health insurance system, initiated in 1945, which attained universal coverage in 2000 by introducing a state-funded insurance program for the poorest part of the population. Targeted subsidies, in the forms of vouchers, financial incentives or copayment removal, have been instrumental in extending access to low-income groups and to those afflicted by long-term disease.

Sources of funding have been broadened in the past 10 years beyond payroll contributions to include a broader range of incomes including from financial assets and investments. SHI provides a comprehensive benefit basket but has cost sharing for all essential services. The increasing reliance on voluntary insurance to cover copayments and other cost sharing is raising concerns about the effectiveness of the redistribution mechanism in the system.

Despite its origins in independent management of social security, the government has come to play a greater role in managing health expenditure through the introduction of spending targets and rigorous monitoring mechanisms for health insurance funds. It has increasingly focused on improving the quality and efficiency of primary care as a key strategy for ensuring equity of access and efficiency of health system. It has also taken steps to transfer greater responsibility to Regional Health Agencies that oversee hospital, ambulatory, and social care for better coordination and accountability locally.

The French experience with pay-for-performance for GPs shows that it could contribute to improving the quality and accountability of providers, but the fee-for-service setting and preponderance of solo primary care practices limit the ability to change clinician behavior for ensuring better care coordination and efficiency. Hospital-payment reforms (DRG) have helped improve hospital productivity but France’s experience shows that effective payment reform also requires strong information systems for monitoring costs and ensuring appropriateness of care, and empowered hospital leadership to better align public and private hospitals with performance standards and to improve accountability overall.
References


